

Date: _____

PATIENT INFORMATION

Chart #: _____

All sections MUST be completed. If not applicable, please indicate as "N/A"

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____ Nickname _____

Sex _____ Birthdate ____/____/____ Age _____ SS# _____ - _____ - _____ Marital Status: S M W D

Permanent Address _____ Apt# _____ City _____ State _____ Zip _____

Home Phone (____) _____ - _____ Work Phone (____) _____ - _____

Cell Phone (____) _____ - _____ Email _____

Employer/School Name _____ Employed: Full Time Part Time Student: Full time Part time

Driver's License # & State _____ Primary Care / Family Physician's Name _____

Have you ever been treated by one of our physicians? No Yes, by Dr _____ Approximate Date _____

Was your injury sustained on the job? Yes No If yes, has a claim been filed with your employer? Yes No

EMERGENCY CONTACT

1st Name _____ Phone (____) _____ - _____ Hm Wk Cell Relationship _____

2nd Name _____ Phone (____) _____ - _____ Hm Wk Cell Relationship _____

REFERRED BY Doctor Hospital/Clinic Patient Friend/Co-Worker Family Member HMO/PPO Directory

Employer Referral Service Yellow Pages Print Advertising TV Internet Radio School Other _____

If referred by a physician: Last Name _____ First Name _____ Phone # _____

If referred by another source, list specific name (i.e hospital, school, or friend's name) _____

PRIMARY INSURANCE (complete blanks below with insured's information)

SECONDARY INSURANCE (complete with insured's information)

Insured's Name _____

Insured's Name _____

Sex _____ Date of Birth _____ SS# _____

Sex _____ Date of Birth _____ SS# _____

Patient's Relationship to Insured _____

Patient's Relationship to Insured _____

Employer _____

Employer _____

Employer's Address _____

Employer's Address _____

City _____ State _____ Zip _____

City _____ State _____ Zip _____

Insurance Co Name _____

Insurance Co Name _____

Phone # (____) _____ - _____

Phone # (____) _____ - _____

Claims Filing Address _____

Claims Filing Address _____

City _____ State _____ Zip _____

City _____ State _____ Zip _____

ID# _____ Group # _____

ID# _____ Group # _____

GUARANTOR (if other than patient) Last Name _____ First Name _____ M.I. _____ Sex _____

Birthdate _____ SS#: _____ - _____ - _____ Driver's License # & State _____ Relationship to patient _____

Permanent Address _____ Apt# _____ City _____ State _____ Zip _____

Home Phone (____) _____ - _____ Work Phone (____) _____ - _____ Cell Phone (____) _____ - _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby consent to releasing information for the purposes of treatment, payment, or health care operations.
ASSIGNMENT OF BENEFITS: I hereby authorize my insurance benefits to be paid directly to Austin Sports Medicine. **CONSENT FOR TREATMENT:** I hereby consent to necessary examination procedures and/or treatment by my physician, his/her assistants, designees as is necessary in his/her judgment.

Date _____ Signature (patient, parent, or guardian) _____ Relationship _____

Acknowledgement of Review of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

Patient Name: _____ Account Number: _____

Signature: _____ Date: _____

Relationship to Patient (if other than patient): _____

FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions, please discuss them with our billing staff or office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

- Payment is due at the time of service unless other arrangements have been made in advance by either yourself or your health coverage carrier. For your convenience, we will accept cash, check, and most major credit cards.
- Your insurance is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor; in other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
- We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. If you are covered by one of these plans, we will bill your plan and will only require you to pay the copayment at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for unscheduled services provided in the hospital. Any balance remaining, after your health plan pays, is your responsibility. Payment is due upon receipt of statement from our office.
- Your estimated portion of our fees for scheduled surgical procedures is due prior to the surgery date. Any balance remaining, after your health plan pays, is your responsibility. Payment is due upon receipt of statement from our office.
- We will look to the adult accompanying a minor for all services rendered to minor patients.

All surgery includes a 60- to 90-day period of postoperative office visits, as established by your health plan. This does not include x-rays, physical therapy, or durable medical prescribed.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

SIGNATURE OF PATIENT or RESPONSIBLE PARTY IF A MINOR

PRINTED NAME

DATE

WORKER'S COMP DISCLOSURE

If you are seeking care at this facility for an injury/condition that occurred due to work, please note that we are required by the Texas Worker's Compensation Commission law to handle your claim with your employer's workers compensation insurance carrier (pursuant to TWCC Rule 120.1 & 120.2). Please mark the applicable statement:

_____ I certify that my injury/condition IS work related

_____ I certify that my injury/condition is NOT work related.

SIGNATURE OF PATIENT or RESPONSIBLE PARTY IF A MINOR

PRINTED NAME

DATE

MEDICAL HISTORY

Please complete all sections and indicate if non-applicable.

Name _____ Date _____ Age _____ Sex (Circle one) M / F

Primary Physician (provide first & last name) _____ Height _____ Weight _____

ILLNESSES / REVIEW OF SYSTEMS (Provide details to all yes answers)

| Yes | No | Details | Medication |
|--------------------------|--------------------------|---|------------|
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Problems/Pacemaker/Chest Pain _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma/Lung Disease/Shortness of Breath _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis/Liver Disorders _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding Problems/Stroke _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Clots/Phlebitis _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Bladder Infections _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach Ulcer/Bleeding _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression/Mental Illness _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Change _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Eyes, Vision Change _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear, Nose, Throat, Mouth Problems _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizure _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness/Tingling _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other Illness/Hospitalization _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Previous Bone or Joint Problems _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other Sports Injury _____ | _____ |

DRUG ALLERGIES (Check yes or no)

Yes No
 If yes, provide details _____

LATEX ALLERGIES (Check yes or no)

If yes, provide details _____

OTHER MEDICATIONS (current/recent)

Yes No
 Diuretics _____
 Blood Thinners _____
 Steroids/Cortisone _____
 Weight Control _____
 Sleeping Pills _____
 Antibiotics _____
 Pain Pills _____
 Aspirin _____
 Anti-inflammatories (e.g. Advil) _____
 Herbals/Vitamins/Supplements _____
 Other _____

Yes No
 PREVIOUS SURGERY (type and dates) _____

 FAMILY HISTORY (illness, reactions to anesthesia) _____

 RECENT TEST RESULTS (EKG, chest x-ray, blood or HIV tests, etc.) _____

 RECENT ILLNESSES OR SYMPTOMS _____

 SMOKE? (pack/day) _____
 DRINK? (how often?) _____

WOMEN ONLY

Pregnant? _____
Birth Control (type) _____
Date Last Period Started _____
Normal? _____

| For Office Use only | Date / Initials |
|----------------------------|-----------------|
| History Reviewed / Updated | _____ |
| History Reviewed / Updated | _____ |
| History Reviewed / Updated | _____ |
| History Reviewed / Updated | _____ |

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person, except when you have authorized us to do so. I have read and answered completely and accurately.

SIGNATURE _____ **DATE** _____